Within corporate limits
Pl Simon

06800

157e

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 1 hour 25 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Crescent Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Donald Lester Alkire

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 23, 1944

8. AGE: Years	Months	Days	If less than one day
3	9	2	hrs. min.

9. Birthplace: Chicago, Illinois
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Paul L. Alkire
13. Birthplace: Cumberland, Maryland

MOTHER
14. Maiden name: Dorothy Jean Crawford
15. Birthplace: Keyser, West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jul. 28 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Bur. Park Cem.

Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.

19. July 28 1948 (Date rec'd by registrar) Wol. Fantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1948 at 9:40PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him ~~alive~~ on Dead on July 26 1948

Immediate cause of death: Acute cardiac decomposition — DURATION

Due to: Congenital patent interventricular septum

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Skitarelic M.D. M. D. or other

Address: Memorial Hospital Date signed July 26 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

068801

93d Dr Paul R. Wilson

1. PLACE OF DEATH:
County: Allegany
City or town: Moscow - rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 85 years
Hospital, Institution, or street address where death occurred:
1 mile east of Moscow
How long in hospital or institution? - - - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Moscow - rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1 mile east of Moscow
(If rural, give LOCATION)
2.(a) If veteran, name war: - - - - - - -

3.(a) FULL NAME
MARY JANE ANDREWS

3.(b) Social Security Number
- - - - -

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: George W. Andrews
6.(c) If alive, give age: - - years

7. Birth date of deceased (mo., day, yr.): December 28, 1862

8. AGE: Years 85 | Months 6 | Days 14 | If less than one day: hrs. min.

9. Birthplace: Moscow, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER
12. Name: John Shaw
13. Birthplace: England

MOTHER
14. Maiden name: Nancy Michaels
15. Birthplace: Westernport, Maryland

16. Informant: Mrs William R. Miller
Address: Moscow, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: July 15, 1948
(month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Moscow, Maryland

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Maryland

19. July 15 1948 [illegible] MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1948 at 2:10pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1948 to July 12 1948 and that I last saw her alive on July 10 1948

Immediate cause of death	DURATION
Chronic Myocarditis and Myocardial Degeneration Not specified as Rheumatic	3 Years
Due to	
Due to	
Other conditions: Pulmonary Edema	2 Day

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul R. Wilson M.D.
M. D. or other
Address: Piedmont, W. Va. Date signed: 7-14-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of birth date and age shown on:

FILM No. G 116 JUL 26 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

06802

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Entire time

Hospital, Institution, or street address where death occurred: 168 E. Loo St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 168 E. Loo St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Isabella G. Arnold

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Wm. P. Arnold

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 28-1858

8. AGE: Years 89 Months ~~10~~ 9 Days ~~18~~ 2 If less than one day ..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: Henry R. Atkinson

13. Birthplace: Maryland

MOTHER 14. Maiden name: Eleanor Slider

15. Birthplace: Pan Pan W. Va.

16. Informant: Mrs. Laird Plummer

Address: 162 E. Loo St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-19-1948 (month) (day) (year)

Cemetery or crematory: Percy Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Hagner

Address: Frostburg, Md.

19. 7-19 1948 Mrs. Nancy H. Roe Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 July 1948 at 10 45 P M EST

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 July 1948 to 16 July 1948 and that I last saw h... alive on 16 July 1948.

Immediate cause of death: Cardiac decompensation & failure — DURATION

Due to: Severe cholecystitis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results: none done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: John B. Davis M. D. ~~or other~~

Address: 2 Broadway, Frostburg Md. Date signed 17 July 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-25-1947

Within corporate limits

WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

06803

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 10days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 WILMONT AVENUE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
MARY M. BARTLETT

3. (b) Social Security Number
None

4. Sex: FEMALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: WIDOW

6.(b) Name of husband or wife: ELMER JAMES BARTLETT

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): FEBRUARY 4, 1878

8. AGE: Years 70 Months 5 Days 14 If less than one day hrs. min.

9. Birthplace: WEST VIRGINIA
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER
12. Name: LOUIS WILSON ROBINSON
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: HANNAH HATTHAWAY
15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland, Md.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. July 21, 1948 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 18, 1948 at 8:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw her alive on 18 July 1948

Immediate cause of death: Cardiac Failure — DURATION

Due to: Chr. Myocarditis

Chr. Sclerosis hypertension

Due to: Coronary Sclerosis

Other conditions: Post-operative appendectomy 10 days
(Include pregnancy within 3 months of death)

Major findings of operation: Acute Gangrenous Appendicitis Date of op. 8 July 48

Autopsy results: as above recorded.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Fuller B. Whitworth M. D. or other

Address: 112 Bedford St. Date signed 18 July 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. H. Litwack

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

44b

06804

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 Yrs.

Hospital, institution, or street address where death occurred:
12 Smith St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Smith St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Mildred Irene Bender

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Christopher C. Bender

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Jan. 10, 1894

8. AGE:

Years	Months	Days	If less than one day
54	5	27	... hrs. ... min.

9. Birthplace: Rainsburg, Penna.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William H. Schaffer
13. Birthplace: Penna.

MOTHER
14. Maiden name: Anna Bortz
15. Birthplace: Penna.

16. Informant: Mr. Christopher C. Bender
Address: 12 Smith St. Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: July 9, 1948
(month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. July 8 1948 W. R. Lantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7, 1948, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1948, to July 7 1948
and that I last saw her alive on July 4 1948

Immediate cause of death: Hodgkins Disease — DURATION 3 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charlotte B. Gardner, M.D.
M. D. or other

Address: Cumberland, Md. Date signed: July 7, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charlea St., Baltimore

94a

C6805

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
in route to Allegany Hospital
How long in hospital or institution? dead on arrival.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 428 Walnut St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Arnold S. Bennett

3. (b) Social Security Number
214-07-1202

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Frances Perdew Bennett
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): March 13-1894

8. AGE: Years	Months	Days	If less than one day
54	4	1	hrs. min.

9. Birthplace: Chaneysville Pa.
(Town, county, and state)
10. Usual occupation: Carpenter foreman
11. Industry or business

FATHER
12. Name: Joseph H. Bennett
13. Birthplace: Pa.

MOTHER
14. Maiden name: Sarah Robinette
15. Birthplace: Iowa.

16. Informant: Mrs. Frances P. Bennett
Address: 428 Walnut St. Cumberland Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: July 17, 1948
(month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Md.
18. Funeral director: John J. [illegible]
Address: Cumberland, Md.

19. July 15, 1948
(Date rec'd by registrar)
W.R. Trautz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 19 48 at about 2.20A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw him alive July 14 19 48
Immediate cause of death: Coronary occlusion — DURATION: at once
Due to: coronary sclerosis
Due to:
Other conditions: old myocardial infarct
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury — Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D.
M. D. or other
Address: Cumberland Md. Date signed: 7-14-48

VS A15 9-45-15M

Within corporate limits

DR. ~~JACOBSON~~ Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

06806

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: GARRETT

City or town: KITZMILLER
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

MR. RICHARD B. BRAY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 20, 1871

8. AGE: Years	Months	Days	If less than one day
77	0	26	hrs. min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)

10. Usual occupation: FARMER

11. Industry or business

FATHER 12. Name: NORMAN B. BRAY
13. Birthplace: MARYLAND

MOTHER 14. Maiden name: DUXIB, SARAH A.
15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVE.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/18/48 (month) (day) (year)

Cemetery or crematory: Bray Cemetery

Location: Kitzmiller, Md.

18. Funeral director: O.F. Sharpless
Address: Blaine, W. Va.

19. July 17, 1948 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 16, 1948 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1948 to July 16 1948 and that I last saw him alive on July 15 1948

Immediate cause of death	DURATION
Chr. Nephritis	?
Due to: Chr. Myocarditis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson for M. D. or other

Address Cumberland Md. Date signed 7-16-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

M I T

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157g

C6807

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. #5 Winchester Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Dennis Wallis Breedlove

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Apr. 23, 1948

8. AGE:

Years	Months	Days	If less than one day
1	2	26	hrs. min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Meredith Breedlove
13. Birthplace: Akron, Ohio.

MOTHER
14. Maiden name: Elva Simmons
15. Birthplace: Franklin, W. Va.

16. Informant: Mr. Meredith Breedlove
Address: R.D. #5 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22 1948 (month) (day) (year)

Cemetery or crematory: HillCrest

Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. July 22 1948 (Date rec'd by registrar) W. R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1948, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1948 to July 19 1948 and that I last saw him alive on July 19 1948

Immediate cause of death	DURATION
peritonitis	4 days
Due to: strangulated diaphragmatic hernia	4 days
Due to: congenital malformation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results: strangulated diaphragmatic hernia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. Rivings M.D. M. D. or other

Address: 39 Greene St. Date signed 7-20-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124 b

06808

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 Yrs 6 Mo 28 Days

Hospital, Institution, or street address where death occurred: 306 Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Bedford St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma Lotta Daughtrey

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Harvey W. Daughtrey

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): December 20 1878

8. AGE: Years	Months	Days	If less than one day
69	6	28	... hrs. ... min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: James A Buckey
13. Birthplace: Buckeystown, Md.

MOTHER
14. Maiden name: Louisa Mayer
15. Birthplace: Cumberland, Md.

16. Informant: Mrs Keith Sisk
Address: 306 Bedord St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/20/48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 20 1948 (Date rec'd by registrar) W. L. Lauck M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1947 to July 18 1948 and that I last saw h.e. alive on July 17 1948

Immediate cause of death: Cerebral Thrombosis

DURATION: 1 yr 2 mo.

Due to:

Due to:

Other conditions: Syphilis (Left) ? ?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel Jacobson M.D. M. D. or other

Address: 50 Pershing St Date signed 7/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83 a

06809

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 14 hours

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? about 14 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Old Town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Mrs. Bertha Davis

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: John Davis

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): 3-1-1901

8. AGE: Years: 47 Months: 4 Days: 18 If less than one day: hrs. min.

9. Birthplace: Oldtown, Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: Piper, Micheal
13. Birthplace: Md

MOTHER
14. Maiden name: Hamilton, Elmira
15. Birthplace: Md.

16. Informant: John M Davis
Address: Old town, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-23-48 (month) (day) (year)

Cemetery or crematory: Cemetery
Location: Oldtown, Md.

18. Funeral director: John E Walter, Md
Address: 125 S Liberty St. Cumberland Md

19. July 22 (Date rec'd by registrar) 19 48 W. H. Lantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 19 48 at 4.40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw her alive July 19 19 48 Dead

Immediate cause of death: Cerebral hemorrhage — Duration: about 36 hours

Due to: rupture of Circle of Willis

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V.Deming M.D. H.V. Deming M.D. (M. D. or other)

Address: Cumberland Md Date signed: 7-19-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

175 C

06810

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? about 7-1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Rural) R.F.D 2 Baltimore Pike
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Cumberland, Rural
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Charles Hughes Davis

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28-1878

8. AGE: Years	Months	Days	If less than one day
70	2	1	hrs. min.

9. Birthplace Gilpintown Allegany, Md.
(Town, county, and state)

10. Usual occupation farmer

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden name ?
15. Birthplace

16. Informant Charles Vergon
Address LaVale, Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof August 1, 1948
(month) (day) (year)

Cemetery or crematory Pleasant Grove Cemetery

Location Rt. 40, near Cumberland, Md.

18. Funeral director John J. Hafer
Address Cumberland, Md.

19. July 31 1948 W. H. Frank, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1948 at 11.10PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1948, to 1948
and that I last saw him alive July 29 1948

Immediate cause of death: Intracranial hemorrhage — DURATION: about 8 hrs.

Due to: Basal fracture of the Skull

Due to:

Other conditions: Hematoma underneath scalp at vertex.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-29-48

Where did injury occur? near Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) farm

Means of injury Fell from load of hay on head Injured at work? yes

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V.Deming M.D. H. V. Deming M.D.
M. D. or Coroner

Address Cumberland Md. Date signed 7-29-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

[redacted] Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170C

06811

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hours

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: West Virginia County: ~~Hampshire~~ Mineral

City or town: ~~Augusta~~ Keyser

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Calvin Lloyd Dawson

3.(b) Social Security Number 232-26-1605

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Pearl Dawson

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 27, 1911

8. AGE: Years	Months	Days	If less than one day	
~~About~~ 37	0	8	... hrs.	... min.

9. Birthplace: Petersburg, Grant Co., W. Va. (Town, county, and state)

10. Usual occupation: auto Mechanic-unemployed at present

11. Industry or business

FATHER 12. Name: Charles Dawson

13. Birthplace: West Virginia

MOTHER 14. Maiden name: Blanche Hannon

15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7, 1948 (month) (day) (year)

Cemetery or crematory: Ebenezer Cem.

Location: Augusta, W. Va.

18. Funeral director: W. H. McKee

Address: Augusta, W. Va.

19. July 5 1948 (Date rec'd by registrar) W. R. Haught, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5, 1948 at 5:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1948 to July 5, 1948 and that I last saw him Dead July 5, 1948

Immediate cause of death: Intracranial hemorrhage & shock. — DURATION: about 6 hrs.

Due to: Basil fracture of the skull

Due to:

Other conditions: laceration of scalp & lacerations of both legs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Auto.accident Date of 7-5-48

Where did injury occur? Route 50, Fort Hill, Mt. Lonney (City or town) (County) Hampshire Co. (State) W. Va.

Injured at home, farm, industry, public place (where?) Highway

Means of Injury: Auto accident. Injured at work? No

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. (M. D. or other)

Address: Cumberland Md. Date signed 7-5-48

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

T

06812

157g

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8 9

1. PLACE OF DEATH:

County: Alleghany

City or town: Frostburg Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Hours

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 6 Hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Alleghany

City or town: Woodland Route 1 Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: –
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: Baby Dunsmore

3. (b) Social Security Number: –

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Child

6.(b) Name of husband or wife: –

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): June 23, 1948

8. AGE: Years | Months: 1 | Days: 2 | If less than one day: hrs. min.

9. Birthplace (town, county, and state): Frostburg Alleg. Md

10. Usual occupation: Blacksmith Helper

11. Industry or business: Rail Road

FATHER
12. Name: Vincent Dunsmore
13. Birthplace: Lonaconing Md

MOTHER
14. Maiden name: Betty Marie Magley
15. Birthplace: Woodland, Md

16. Informant: Mrs Vincent Dunsmore
Address: Woodland, Md Route 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 27 48 (month) (day) (year)

Cemetery or crematory: Alleghany Cemetery

Location: Frostburg Md

18. Funeral director: M. Eichlorn

Address: Lonaconing Md

19. July 27 1948 Jeanette M. Boal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1948, at 11:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1948 to July 26 1948 and that I last saw him alive on July 26 1948

Immediate cause of death: Congenital Heart — DURATION: 1 mo

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. J. McGuire M.D.
M. D. or other

Address: Frostburg Md Date signed: 7-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits DR. W.F.WMS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06813

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY COUNTY

City or town: CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 YRS- 1 MO. 8 Days

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 423 HENDERSON AVE.,

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: MRS. ELIZABETH DIEHL

3.(b) Social Security Number: None

4. Sex: FEMALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: WIDOWED

6.(b) Name of husband or wife: PHILIP SHERIDAN DIEHL

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): JUNE 5, 1877

8. AGE: Years 71 | Months 1 | Days 8 | If less than one day ____ hrs. ____ min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: HWFE

11. Industry or business:

FATHER — 12. Name: PHILIP SMITH

13. Birthplace: GERMANY

MOTHER — 14. Maiden name: CHRISTINA NICKLE

15. Birthplace: MARYLAND

16. Informant: MEMORIAL HOSPITAL

Address: MEMORIAL AVE., CITY

17. Burial (Burial, cremation, or removal. Where?) Date thereof July 15 '48 (month) (day) (year)

Cemetery or crematory: St Peters Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. July 15, 1948 (Date rec'd by registrar) W.L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 13, 1948 at 2:05A P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1-48 to 7-13-48 and that I last saw her alive on 7-12-48

Immediate cause of death	DURATION
Chronic Hypertensive Heart Disease.	
Due to: Chronic Myocardial Degeneration.	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?: ____

23. SIGNATURE: W.F. Williams M. D. or other

Address: Cumberland Date signed: 7-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street address is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

06814

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 126 Virginia Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EVA ELLEN DROEGE

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William O. Droege

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): June 27, 1885

8. AGE: Years	Months	Days	If less than one day
63	0	16	hrs. min.

9. Birthplace: Thayerville, Garrett Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Charles Casteel
13. Birthplace: Garrett Co. Maryland

MOTHER
14. Maiden name: Elizabeth (Unknown)
15. Birthplace: Garrett Co, Md.

16. Informant: Mr. William O. Droege
Address: 126 Virginia Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 15, 1948 (month) (day) (year)

Cemetery or crematory: Oakland Cemetery

Location: Oakland, Maryland

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. July 15 19 48 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-13-48 19 at 12 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-21-48 19 to 7-13-48 19 and that I last saw her alive on 7-12- 19

Immediate cause of death	DURATION
Gen'l Myocarditis due to	
Due to: Hypostatic Pneumonia	3 days
Due to:	
Other conditions: Ch. Appendicitis	

(Include pregnancy within 3 months of death)

Major findings of operation: Ch. Appendicitis 7-9-48
Cosm Goiter Date of op. 5-27-48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Cumberland Md. Date signed: 7/4-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

I

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06815

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution? 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 721 Patterson Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME Charles Morgan Fisher

3.(b) Social Security Number 217-10-6540

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ada "Woodmancy" Fisher

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 21, 1874

8. AGE:

Years	Months	Days	If less than one day
73	11	5	____ hrs. ____ min.

9. Birthplace: Somerset, Pennsylvania
(Town, county, and state)

10. Usual occupation: Retired Blacksmith

11. Industry or business: Kelley Springfield Tire Co.

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Mrs Laura Diehl

Address: 75 Main St., Frostburg, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Maryland

18. Funeral director: John J. Hafer

Address: Cumberland, Maryland

19. July 29, 1948 (Date rec'd by registrar) W.K. Trauth, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9, 1947 to July 26, 1948 and that I last saw him alive on July 26, 1948

Immediate cause of death	DURATION
Cerebral Vascular Accident	3 days
Due to: Generalized Arteriosclerosis	4 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed: 7-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore.

CERTIFICATE OF DEATH

93d

16816

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred: 548 Fairview Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 548 Fairview Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Agnes A. Guenterberg

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Bernard Guenterberg

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan 9 1865

8. AGE: Years 83 | Months 6 | Days 10 | If less than one day ... hrs. ... min.

8. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home.

FATHER

12. Name: — Hymann

13. Birthplace: Germany

MOTHER

14. Maiden name: Unknown

15. Birthplace:

16. Informant: Miss Frances Guenterberg

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 22 48 (month) (day) (year)

Cemetery or crematory: St Peter & Paul's Cem

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. July 21 19 48 (Date rec'd by registrar) W. L. Frank, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 19 48 at 7 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to July 19 19 48 and that I last saw ... alive on July 17 19 48

Immediate cause of death: Vascular Disease

Due to: Senility

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION
Yrs.
Yrs.

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Wm B Dawson M.D. M. D. or other

Address: 1331 a Ave Date signed: 7/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

M I T

Dr. Eliason

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160C

06817

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9½ HOURS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 9½

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Grant

City or town: Mt. Storm
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mt. Storm, West Virginia
(If rural, give LOCATION)

2.(a) If veteran, name war: /

3. (a) FULL NAME
Larry Earl Hanlin

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 27, 1948

8. AGE: Years | Months | Days: 4 | If less than one day: hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Haven E. Hanlin
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Vauda Cosner
15. Birthplace: West Virginia

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVE.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/1/48 (month) (day) (year)

Cemetery or crematory: Cosner Cemetery

Location: Bismark, W. Va.

18. Funeral director: O. F. Sharpless.

Address: Blaine, W. Va.

19. July 31, 1948 (Date rec'd by registrar) W. L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1948 at 12-30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1948 to July 27 1948 and that I last saw him alive on July 27 1948

Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 days

Due to: Difficult Prolonged Labor

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm F. McFarland M. D. or other

Address: Cumpton Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

Bamm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

06818

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 HRS & 15 MIN

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 4 HRS AND 15 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: Near CUMBERLAND Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. ~~Narrows Park~~ Rt. #6

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: BABY BOY HORN

3.(b) Social Security Number: None

4. Sex: MALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 11, 1948

8. AGE: Years | Months | Days | If less than one day: 4 hrs. 15 min.

9. Birthplace: Cumberland Allegany Md (Town, county, and state)

10. Usual occupation: Baby

11. Industry or business

FATHER 12. Name: HORN, ROBERT L.

13. Birthplace: MARYLAND

MOTHER 14. Maiden name: WILES, MARY A

15. Birthplace: W. VA

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND MD

17. Cremation (Burial, cremation, or removal. Which?) Date thereof July 11, 1948 (month) (day) (year)

Cemetery or crematory: Hospital Disposal

Location:

18. Funeral director: Memorial Hosp.

Address: Cumberland Md.

19. July 11, 1948 (Date rec'd by registrar) C. R. Fritz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11, 1948, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 July 1948 to 11 July 1948 and that I last saw him alive on 11 July 1948

Immediate cause of death: Atelectasis — DURATION

Due to: Prematurity

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: LeGand A. Cauromell M. D. or other

Address: 41 Greene St. Cumberland Date signed: 11 July 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

152

06819

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 Years

Hospital, institution, or street address where death occurred:
Rt 3, Valley Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 3, Valley Road
(If rural, give LOCATION)

2.(a) If veteran, name war: First World War

3. (a) FULL NAME
Walter James Hughes

3. (b) Social Security Number
213-16-9344

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie (Gentry) Hughes

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): May 31, 1895

8. AGE: Years	Months	Days	If less than one day
53	1	2	hrs. min.

9. Birthplace: Hancock, Washington Co, Maryland
(Town, county, and state)

10. Usual occupation: Electrical Helper

11. Industry or business: Kelly Springfield Tire Co

FATHER
12. Name: John F. Hughes
13. Birthplace: Wales

MOTHER
14. Maiden name: Surenna Norris
15. Birthplace: Hancock, Md.

16. Informant: Mrs Walter J. Hughes
Address: Rt 3 Valley Road, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/6/48 (month) (day) (year)

Cemetery or crematory: Presbyterian Cemetery

Location: Hancock, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md

19. July 6, 1948 (Date rec'd by registrar) W. R. Lanty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3, 1948, at 12-05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 1948, to July 3, 1948, and that I last saw him alive on June 25, 1948.

Immediate cause of death	DURATION
Uraemia	2 wks.
Due to: Malignant Hypertension	18 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D. or other

Address: Cumberland Date signed: 7/3/48.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

93d

06820

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Gilmore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Gilmore
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME
Ella Gray Stewart James

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Thomas James
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): May 15, 1870

8. AGE:

Years	Months	Days	If less than one day
78	2	3	hrs. min.

9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home

FATHER
12. Name: James Stewart
13. Birthplace: Ayrshire, Scotland

MOTHER
14. Maiden name: Mary Beveridge
15. Birthplace: Ayrshire, Scotland

16. Informant: Mrs George Lintz
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21, 1948 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.

19. July 21 1948 Jeanette M. Bond
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1948, at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to July 17 1948 and that I last saw her alive on July 17 1948

Immediate cause of death	DURATION
Stroke	
Arteriosclerosis	2 yrs
Due to: Chronic myocarditis	2 yrs
Due to: Bronchial pneumonia (terminal)	1 day
Other conditions: Decubitus	1 month

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Thomas Reese, M.D. (M. D. or other)
Address: Westernport, Md. Date signed: 7/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

06821

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:
Sylvan Retreat

How long in hospital or institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Vine Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida May Kalbaugh

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Richard Kalbaugh

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 21, 1875

8. AGE:

Years	Months	Days	If less than one day
73	0	14	..... hrs. ..... min.

9. Birthplace: Westernport, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: J. D. Kalbaugh
13. Birthplace: Garrett County, Maryland

MOTHER
14. Maiden name: Mary Susan Simmons
15. Birthplace: West Virginia

16. Informant: Mrs. Bess Kalbaugh
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 7 1948 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport, Md.

18. Funeral director: Boals Funeral Home
Address: Westernport, Md.

19. July 6, 1948 (Date rec'd by registrar) W. F. Tanty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1948 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1947 to July 5 1948 and that I last saw h~~er~~ alive on July 2 1948

	DURATION
Immediate cause of death: Myocardial Failure	5 min
Due to: Chronic Myocarditis	4 yrs.
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: ..... Injured at work?

23. SIGNATURE: Arthur F. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed: 7-6-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06822

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred: Front Street

Now long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: Front Street (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Anna M. Stark Kiddy

3.(b) Social Security Number: —

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Matthew Kiddy

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct 7, 1868

8. AGE: Years 79 | Months 9 | Days 8 | If less than one day ... hrs. ... min.

9. Birthplace: New Germany, Garrett Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: Peter Stark

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: C. A. Broster

MOTHER 15. Birthplace: Garrett County Md.

16. Informant: Mrs. Richard Beagian

Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 18, 1948 (month) (day) (year)

Cemetery or crematory: Moscow Cemetery

Location: Moscow, Maryland

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. July 18 1948 (Date rec'd by registrar) Jannette M. Pool Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/15 1948, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/15 1948 to 7/15 1948 and that I last saw her alive on Not Seen 19...

Immediate cause of death: Coronary thrombosis

Due to: Arteriosclerosis

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: Burl Eugene Frye M.D. M. D. or other

Address: Lonaconing, Md. Date signed: 7/17/48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160C

06823

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 da

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 103 N Oldtown Rd (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME ~~Baby Boy~~ Kines, Charles William Walter, Jr.

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

7.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 29 1948

8. AGE: Years | Months | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER 12. Name: Charles Wm Walter Kines Jr.

13. Birthplace: Cumberland Md

MOTHER 14. Maiden name: Jeanette Ellis

15. Birthplace: Martinsburg W. Va.

16. Informant: Wm Kines

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 2 48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. July 31 1948 (Date rec'd by registrar) Monte R Trout M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1948 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1948 to July 30 1948 and that I last saw him alive on July 30 1948

Immediate cause of death: prematurity — DURATION

Due to: placenta previa

Due to: Marginata

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Wm L McFarland M. D. or other

Address: Accident. Date signed: 7-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

06824

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
164 E. College Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 164 E. College Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Jeanette McIntyre Kyle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Kyle
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Nov. 14th, 1860

8. AGE: Years: 87 yrs | Months: 8 mo | Days: 17 | If less than one day ... hrs. ... min.

9. Birthplace: Barton, Md.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER 12. Name: David McIntyre
13. Birthplace: Unknown
MOTHER 14. Maiden name: Mary Ellen Barnes
15. Birthplace: Barton, Md.
16. Informant: Irvin Kyle
Address: 16 Hill Street Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-2-48 (month) (day) (year)
Cemetery or ~~crematory~~: Allegany
Location: Frostburg Md
18. Funeral director: Jacob T. Haber
Address: 23 E. Main St, Frostburg Md
19. 8-1 1948 Mrs. Nancy H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1948 at 6:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1948 to July 31 1948 and that I last saw her alive on July 30 1948
Immediate cause of death: Chr Myocarditis — Duration: Several months
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. D. McLane M.D. M. D. or other
Address: Frostburg Md. Date signed 7-31-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

I

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

188

06825

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15-1/2 hours

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 15-1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montg.

City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 26 Diamond Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Benjamine Mr. (Benny) Leggett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Letitia Lindsay

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): September 25, 1925

8. AGE: Years	Months	Days	If less than one day
22	10	0	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Jockey

11. Industry or business: Horse Racing

FATHER
12. Name: Bisco Leggett
13. Birthplace: North Carolina, Williamston

MOTHER
14. Maiden name: Elsie Ayers
15. Birthplace: Virginia, Roanoke

16. Informant: Memorial Hospital (mother)
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal) Which? Date thereof: July 29, 1948 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Bethesda, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. July 26 1948 (Date rec'd by registrar) W. R. Fautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1948 at 8:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1948 to July 25 1948 and that I last saw him alive on 1948

Immediate cause of death: Severe concussion and contusion of brain — DURATION: 17 hrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 7-24-48

Where did injury occur? Fairgo, near Cumberland (City or town) Allegany (County) Md (State)

Injured at home, farm, industry, public place (where?): Race track, Fairgo

Means of injury: Horse hit fence Injured at work? yes

Jockey thrown about 25 feet striking head on ground.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
Deputy Medical Examiner - Allegany Co.

Address: Cumberland Md. Date signed: 7.25-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

06826

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Loartown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Loartown - Frostburg R.F.D. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Price A. Loar

3.(b) Social Security Number: none

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Jean Sherman Loar

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Aug 15 - 1877

8. AGE: Years: 70 Months: 11 Days: 7 If less than one day: hrs. min.

9. Birthplace: Loartown - Alleg. Md. (Town, county, and state)

10. Usual occupation: retired blacksmith

11. Industry or business

FATHER 12. Name: Jacob Loar

13. Birthplace: Loartown, Md.

MOTHER 14. Maiden name: Harriet Loar

15. Birthplace: Loartown, Md.

16. Informant: Mrs Price A. Loar

Address: Loartown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-25-1948 (month) (day) (year)

Cemetery or ~~crematory~~: Vale Summit

Location: Vale Summit Md.

18. Funeral director: J. J. Durst

Address: Frostburg, Md

19. 7-24 1948 Mrs Nancy N. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 July 1948 at 6:40 P.M. EST

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 June 1948 to 22 July 1948 and that I last saw him alive on 10 July 1948

Immediate cause of death: Cerebral Hemorrhage — DURATION

Due to: Hypertension

Due to: Chronic nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: John B. Davis, M.D.

M. D. or other

Address: 2 Broadway, Frostburg, Md. Date signed: 23 July 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

06827

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, Institution, or street address where death occurred: Morgantown, Md.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Morgantown, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James William Lockett

3.(b) Social Security Number 220-03-7761A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6th, 1869

8. AGE: Years	Months	Days	If less than one day
79 yrs.	3	2	hrs. min.

9. Birthplace: Gallatin Tennessee
(Town, county, and state)

10. Usual occupation: Retired Linotype Operator

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Gilbert C. Baker
Address: Morgantown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/11/48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland Md.

18. Funeral director: Jacob Hafer
Address: 23 E. Main St, Frostburg Md.

19. 7-10 1948 Mrs. Nancy H. Rose
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 July 48 1948 at 6 15 EST P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 July 1948 to 7 July 1948 and that I last saw him alive on 4 July 1948

Immediate cause of death: Coronary Thrombosis

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John B. Davis, MD
M. D. or other

Address: Frostburg Md. Date signed 9 July 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06828

51c

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution or street address where death occurred: Oldtown Rd. (Spring Gap) Route #4
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural - Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. #4 Oldtown Rd. (Spring Gap)
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Charles Sylvester Long
3. (b) Social Security Number: 716-18-1458

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Pearl Goff
6.(c) If alive, give age: 39 years
7. Birth date of deceased (mo., day, yr.): April 3 1900
8. AGE: Years 48 Months 3 Days 15 If less than one day ... hrs. ... min.
9. Birthplace: Cumberland Md (Town, county, and state)
10. Usual occupation: Tin Shop
11. Industry or business: Celanese Corp.
FATHER 12. Name: Chas A. Long
FATHER 13. Birthplace: Cumberland Md
MOTHER 14. Maiden name: Ida M Unger
MOTHER 15. Birthplace: Cumberland, Md.
16. Informant: Pearl G Long
Address: Spring Gap. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21, 48 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland
19. July 21 1948 W. R. Frank M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1948 at 7 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1948 to July 18, 1948 and that I last saw him alive on July 1, 1948

Immediate cause of death	DURATION
Carcinomatosis	9 mos
Due to: Primary site: R. Testicle 5/30/48 abc	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Same
(Excision of Testicle) Date of op. 11/47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clay F. Lerrick M. D. or other
Address: Cumberland Date signed: 7/20/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

188

C6829

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 minutes

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa County: Somerset

City or town: (Pocohontas) Meyersdale RFD 3
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 113 (Rural)
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Edward Jerrymiah Lyons

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Viola Fresh Lyons

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): May 15 - 1892

8. AGE:

Years	Months	Days	If less than one day
56			hrs. min.

9. Birthplace: Middle Creek Pa
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Silas Lyons
13. Birthplace: Pa

MOTHER
14. Maiden name: Mary Pleeher
15. Birthplace: Shelton Pa

16. Informant: Mrs Ed. J. Lyons
Address: Meyersdale Pa RFD - 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 12 1948 (month) (day) (year)

Cemetery or crematory: Barron Church Cemetery

Location: Rockwood R.D. 2

18. Funeral director: William Ram Price

Address: Meyersdale Pa. Main St

19. 7-10 1948 Mrs. Nancy K. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1948 at 8:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h. alive on July 9 1948

Immediate cause of death: Intracranial hemorrhage due to a fractured skull — Duration: 2 hrs.

Due to:

Due to:

Other conditions: Fractured ribs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 7-9-48

Where did Injury occur? Pocohontas (City or town) Somerset (County) Pa (State)

Injured at home, farm, industry, public place (where?) In barn on the farm

Means of Injury: Kicked by a horse Injured at work? Yes.

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D. (M. D. or other)

Address: Cumberland Md Date signed: 7-9-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

DR. BURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

200 C

06830

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANM

City or town: CUMBERLAND MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 MINUTES

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 12 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 60I N. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MARTIN, BABY BOY

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE (NB)

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, I948

8. AGE: Years | Months | Days | If less than one day hrs. I2 min.

9. Birthplace: Cumberland, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: MARTIN JAMES, W

13. Birthplace: MARYLAND

MOTHER

14. Maiden name: HANSROTH, JOSEPHINE M.

15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof July I0, I948 (month) (day) (year)

Cemetery or crematory: Prospect Cem.

Location: Orleans Cross Rd. W.Va.

18. Funeral director: James F. Scarpelli

Address: Cumberland, Md.

19. July 9 19 48 Walter R. Trently, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 48, at 3:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Child alive at Birth gave four gasps	
Due to: Unknown	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay F. Burrett M. D. or other

Address Cumberland Date signed 7/9/48.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and fully.

VS A15 9-45-15

M C I

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06831

462

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 Yrs 11 Mo 1 Day

Hospital, Institution, or street address where death occurred: 730 Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 730 Bedford St
(If rural, give LOCATION)

2.(a) If veteran, name war: First World War

3.(a) FULL NAME: Richard P. McCardell

3.(b) Social Security Number: 214-05-4890

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Blanche (Oliver) McCardell

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): August 7 1882

8. AGE: Years: 65 Months: 11 Days: 1 If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Cumberland Police Dept

FATHER
12. Name: Thomas McCardell
13. Birthplace: Williamsport, Md

MOTHER
14. Maiden name: Alice Eve
15. Birthplace: Fredericksburg, Va.

16. Informant: Mrs Richard P. McCardell

Address: 730 Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/10/48 (month) (day) (year)

Cemetery or crematory: Ros e Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 9 1948 Winton R. Beatty, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1948 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/2/45 1948 to 7/8/48 1948 and that I last saw h alive on 7/8/48 1948

Immediate cause of death	DURATION
Carcinoma of Ascending Colon	
Due to: Metastasis to Liver	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D. M. D. or other

Address: Cumberland Date signed 7/8/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

Van Dymer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1396

06832

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pa. County: Bedford

City or town: rural Chaneysville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 1, Flintstone, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Laura Virginia McElfish

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Ralph G. McElfish

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.): September 29, 1887

8. AGE: Years 60 | Months 9 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace: Pratt, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER 12. Name: William Fletcher

13. Birthplace: Clearville, Pa.

MOTHER 14. Maiden name: Nancy Weimer

15. Birthplace: Clearville, Pa.

16. Informant: Ralph G. McElfish

Address: Rt. 1, Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29, 1948 (month) (day) (year)

Cemetery or crematory: Prosperity Christian Cemetery

Location: near Chaneysville, Pa.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. July 29, 1948 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20D. DATE OF DEATH: July 25, 1948, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1948 to July 25, 1948 and that I last saw h. alive on July 25, 1948

Immediate cause of death: Pulmonary Embolus, recent. — DURATION: 3 weeks

Due to:

Due to: Pos-Hysterectomy 15 June 1948

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation: Pos-Hysterectomy 15 June 48 Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. Alfred Van Dyke M. D. or other

Address: Cumberland, Md. Date signed: July 28 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06833

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: R.D. #2 Frostburg Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 159 Finzel
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Alban S. McKenzie

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Ida Agnes McKenzie

6.(c) If alive, give age ..... years: Deceased

7. Birth date of deceased (mo., day, yr.): April 16th, 1877.

8. AGE: Years: 71 yrs Months: 2 mo Days: 27 d If less than one day ..... hrs. ..... min.

9. Birthplace: Somerset County, Penna (Town, county, and state)

10. Usual occupation: Farmer and miner

11. Industry or business: Retired

FATHER
12. Name: Patrick McKenzie
13. Birthplace: Somerset County, Penna

MOTHER
14. Maiden name: Rachel Hutzell
15. Birthplace: Somerset County, Penna

16. Informant: Thomas McKenzie
Address: R.D. #2 Box 159, Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/16/48 (month) (day) (year)

Cemetery or crematory: St. Michael's Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob H. Hafer

Address: Frostburg, Md.

19. 7-15- 1948 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1948 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1948 to July 13 1948 and that I last saw him alive on July 13 1948

Immediate cause of death: Cerebral Hemorrhage — Duration: Sudden

Due to: Arteriosclerosis — Duration: Several years

Due to: — Duration:

Other conditions: Diaphramatic Pleurisy — Duration: 1 week
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. D. McLane M.D.
M. D. or other

Address: Frostburg Md. Date signed 7-14-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

M

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Within corporate limits

124 L

06834

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 606 Maryland Ave
(If rural give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Erwin Sanford McKenzie

3.(b) Social Security Number 705-05-1663

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Freiber

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 28 1891

8. AGE: Years	Months	Days	If less than one day
56	8	13	..... hrs. ..... min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Conductor

11. Industry or business: R. R. Co.

FATHER
12. Name: Samuel E. McKenzie
13. Birthplace: Crisfield Md

MOTHER
14. Maiden name: Caroline Jenkins
15. Birthplace: Corriganville Md

16. Informant: Mrs Margaret F. McKenzie
Address: Cleveland Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 13 '48 (month) (day) (year)

Cemetery or crematory: Greenmount Cem

Location: Cumberland

18. Funeral director: Louis Stein Inc
Address: Cumberland

19. July 13, 1948 (Date rec'd by registrar) W. R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1948 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1948 to July 11 1948 and that I last saw him alive on July 10 1948

Immediate cause of death: Cirrhosis of the Liver — DURATION 8 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. Weiss MD
M. D. or other

Address: 59 Frame St. Date signed: 7-12-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Bingo

Within corporate limits Dr. HAWKINS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

117A

06835

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: WESTERNPORT, MD.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 215 HAMMOND STREET

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MR. EDWARD MORAN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: SARAH WILKINSON

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 1, 1901

8. AGE: Years	Months	Days	If less than one day
46	8	10	hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: COAL OPERATOR

11. Industry or business: Mayor of Westernport

FATHER 12. Name: DANIEL MORAN

13. Birthplace: WEST VIRGINIA

MOTHER 14. Maiden name: LUCY HERSHBERGER

15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL

Address: MEMORIAL AVE., CITY

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 14, 1948 (month) (day) (year)

Cemetery or crematory: Phila Cemetery

Location: Westernport, Md

18. Funeral director: Edward A. Baal

Address: Westernport, Md

19. July 12 1948 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 11, 1948 at 3:55A P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1948 to July 11 1948 and that I last saw him alive on July 10 1948

Immediate cause of death: Acute Dilatation Heart

Due to: Acute Pancreatitis

Due to: Perforated Duodenal Ulcer

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: No Operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: A.H. Hawkins M. D. or other

Address: Cumberland Md Date signed: 7-11-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06836

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Cell in City Jail

How long in hospital or institution? about 20 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Charles William Morrissey

3.(b) Social Security Number
215-20-5141

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Ruth Summerfield

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 30-1904

8. AGE: Years: 43 Months: 10 Days: 29 If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: ~~laborer~~ Machinist

11. Industry or business: B&O RR

FATHER
12. Name: Charles A. Morrissey
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Mary S. Barrett
15. Birthplace: Mt. Savage, Md.

16. Informant: Margaret Morrissey
Address: 110 Bedford St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 2, 1948 (month) (day) (year)

Cemetery or crematory: St. Patrick's Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. July 31, 1948 (Date rec'd by registrar) W. R. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 19 48 at about 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive July 29 1948

Immediate cause of death: Coronary occlusion — DURATION: about 20 hours

Due to: coronary sclerosis

Due to:

Other conditions: cardiac dilatation & cerebral oedema.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: As Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. (M. D. or other)

Address: Cumberland Md. Date signed: 7-29-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06837

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs - 0 day

Hospital, institution, or street address where death occurred: 438 Chestnut St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 438 Chestnut St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME F. Marcellus Mullan

3.(b) Social Security Number 214-05-4237

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marcella Cunningham

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 16 1903

8. AGE:

Years	Months	Days	If less than one day
45	0	0	... hrs. ... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business: Printing Co.

FATHER
12. Name: Thomas Mullan
13. Birthplace: Cumberland Md.

MOTHER
14. Maiden name: Katherine Hummler
15. Birthplace: Cumberland Md.

16. Informant: Mrs F. M. Mullan
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/19/1948 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Sons

Address: Cumberland Md.

19. July 17, 1948 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1948 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1940 to July 16 1948 and that I last saw him alive on 7/16/1948

Immediate cause of death: Coronary occlusion

Due to: Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE J. L. K. Rozum M.D. M. D. or other

Address: Cumberland Md. Date signed 7/17/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

15838

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 627 Elm St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 627 Elm St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jeannette M. Rinker

3. (b) Social Security Number: None

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Henry F. Rinker

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 13, 1870

8. AGE: Years: 78 Months: 5 Days: 3 If less than one day hrs. min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: James S. Muir

13. Birthplace: Scotland

MOTHER

14. Maiden name: Mary Todd

15. Birthplace: Scotland

16. Informant: Miss Ellen Rinker

Address: 627 Elm St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19, 1948 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland, Md.

18. Funeral director: James F. Scarpelli

Address: 108 Virginia Ave

19. July 19, 1948 Winter R. Trantz M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 16, 1948 at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1948 to July 16, 1948 and that I last saw him alive on July 16, 1948

	DURATION
Immediate cause of death: Coronary disease	3 yrs.
Due to: Senility	7 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: MEB Devers MD M. D. or other

Address: 130 V a ave Date signed 7-18-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

98 d

06839

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennslyvania County: Bedford

City or town: Bedford
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt 3,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Henry Tilghman Ruby

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Anna (Melvine Ruby

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 30 1876

8. AGE: Years	Months	Days	If less than one day
71	8	20	..... hrs. ..... min.

9. Birthplace: Chaneysville, Bedford Co, Penna
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER
12. Name: Henry Ruby
13. Birthplace: Chaneysville, Pa

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Harry E. Smith
Address: Bedford Rt 3, Penna

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/23/48 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. July 22 1948 (Date rec'd by registrar) W. H. Hardy M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1948 at 8 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948 to July 20 1948 and that I last saw him alive on July 17 1948

Immediate cause of death	DURATION
Cerebral Encephalopathy	2 wk
Due to: Congestive Heart failure	2 d
Pneumonia, Bronchial	2 d
Due to: Arteriosclerotic Heart Disease	?
Adhesions pericardium	?
Other conditions: Cerebral arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Negative

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: Jerrold G. Weisman M.D. M. D. or other

Address: Cumberland, Md. Date signed 7/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

06840

170C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 5 Minutes

Hospital, institution, or street address where death occurred:
Memorial Hospital,

How long in hospital or institution? about 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Hardy

City or town: ~~Moorefield~~ Moorefield
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Minnie Crites See

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Married

6.(b) Name of husband or wife: Mackson See

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Born-March 19-1911

8. AGE: Years	Months	Days	If less than one day
37	4	4	hrs. min.

9. Birthplace: Hardy County, West Virginia
(Town, county, and state)

10. Usual occupation: Housewife & School Teacher

11. Industry or business: Hardy County Board of Education

FATHER
12. Name: Wilbur Crites
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Minnie P. Parsons
15. Birthplace: West Virginia

16. Informant: Father: Wilbur Crites

Address: Moorefield, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25, 1948 (month) (day) (year)

Cemetery or crematory: Crites Cem.

Location: Near Moorefield, W. Va.

18. Funeral director: P. E. Thrush & Son

Address: Moorefield, W. Va.

19. July 23 1948 (Date rec'd by registrar) W. R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1948 at 1.50P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw her alive on Dead July 23 1948

Immediate cause of death: Exsanguination & Shock — DURATION: one hour

Due to:

Due to:

Other conditions: Compound comminuted fractures of both lower legs, left femur fractured left forearm, lower jaw, laceration of right leg above knee.

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 7-23-48

Where did injury occur? north of Romney Hampshire (City or town) W. Va. (County) (State)

Injured at home, farm, industry, public place (where?) 3 miles of Romney Route 28 Highway

Means of injury: Head on collision between truck & Bus

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H.V.Deming M.D. H. V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 7-23-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

47d

06841

CERTIFICATE OF DEATH

1454

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 Years
Hospital, institution, or street address where death occurred: Rt. 6. Locust Grove
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. 6. Locust Grove
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Howard Shaffer, Jr.

3.(b) Social Security Number: 705-10-8380

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Ada (Porter) Shaffer
6.(c) If alive, give age: 31 years
7. Birth date of deceased (mo., day, yr.): August 27 1912
8. AGE: Years: 35 Months: 11 Days: 3 If less than one day: hrs. min.
9. Birthplace: Frostburg, Allegany Co, Maryland (Town, county, and state)
10. Usual occupation: Labor
11. Industry or business: Rose Hill Cemetery
FATHER 12. Name: Howard Shaffer
13. Birthplace: Frostburg, Md.
MOTHER 14. Maiden name: Carrie Porter
15. Birthplace: Frostburg, Md.
16. Informant: Mrs Ada Shaffer
Address: Rt, 6. Cumberland, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/1/48 (month) (day) (year)
Cemetery or crematory: Mt. Herman Cemetery
Location: Williams Road, Cumberland, Md.
18. Funeral director: William H. Kight
Address: Cumberland, Md.
19. July 31, 1948 (Date rec'd by registrar) W.R. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1948 at 12-15 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1948 to July 30 1948 and that I last saw him alive on July 23 1948
Immediate cause of death: Bronchopneumonia
Due to: Carcinoma of the lung c̄ pulmonary and mediastinal metastasis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
DURATION
Major findings of operation: Inoperable Carcinoma of the Esophagus Date of op. June 1948
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Neville G. Weisman M.D. M. D. or other
Address: Cumberland, Md Date signed: 7/30/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

1.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

06842

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Flintstone
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
William Henry Shircliff

3.(b) Social Security Number
212-18-1585

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret (Smith) Shircliff

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): August 15 1875

8. AGE:

Years	Months	Days	If less than one day
72	10	16	... hrs. ... min.

9. Birthplace: Little Orleans, Md. Allegany County
(Town, county, and state)

10. Usual occupation: Retired Agent

11. Industry or business: Metropolitan Life Ins Co

FATHER
12. Name: Honorious Shircliff
13. Birthplace: Little Orleans, Md

MOTHER
14. Maiden name: Mary Ann Murray
15. Birthplace: Little Orleans, Md.

16. Informant: Miss Leota Shircliff
Address: 215 Decatur St, Cumberland, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 7/5/48 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. July 5, 1948 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1948 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Dec. 47 1948 to 1 July 1948

and that I last saw him alive on 1 July 48 1948

Immediate cause of death: Chronic nephritis with uremia ?
Due to: Diabetes mellitus. ?
Due to: Hypertensive Heart Disease ?
Due to: Generalized arteriosclerosis ?
Other conditions:
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. A. Van Osna, M.D. M. D. or other

Address: Cumberland, Md Date signed 1 July 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06843

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 703 Roberts St.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Ida Mae Shobe

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Nola G. Shobe

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan 6, 1883

8. AGE: Years: 65 Months: 6 Days: 7 If less than one day: ... hrs. ... min.

9. Birthplace: Junior W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Agustus J. Coontz
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Emily C. Shomo
15. Birthplace: W. Va.

16. Informant: Nola G. Shobe
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11 48 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland

18. Funeral director: Louis Stein Inc.
Address: Cumberland.

19. July 9 1948 (Date rec'd by registrar) Winter R. Trenty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1948 at 5 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1948 to July 8 1948 and that I last saw her alive on July 7 1948

Immediate cause of death: congestive heart failure — DURATION: 3 wks

Due to: chronic nephritis — 6 months

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Cumberland Md. Date signed: 7-9-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L. Bruno

Dr Nicholson

Within corporate limits

Evidence for change of birth date shown on:

FILM No. G 116 AUG 9 - 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 b

06844

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 Years

Hospital, institution, or street address where death occurred: 921 Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 921 Bedford St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles L Sisk

3.(b) Social Security Number: ~~[illegible]~~ 705-10-8380

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Amanda Sisk

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): September 28 ~~1863~~ 1873

8. AGE: Years	Months	Days	If less than one day
74	9	29	hrs. min.

9. Birthplace: Claysville, Mineral Co, West Va.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Carpenter

FATHER
12. Name: James H. Sisk
13. Birthplace: Claysville, W. Va.

MOTHER
14. Maiden name: Harriot Fetters
15. Birthplace: Claysville, W. Va.

16. Informant: Mrs. Wm. H. O'Neal
Address: 1205 Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 29 1948 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1948 to July 27 1948 and that I last saw alive on July 27 1948

	DURATION
Immediate cause of death: Cerebral thrombosis accident (Hemiplegia)	May 8 '48
Due to: Chronic diffuse glomerulonephritis [8/20/45 abs]	
Due to:	
Other conditions: Uremia - Cataracts . . .	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel Jacobson M.D. M. D. or other

Address: 50 Pershing St Date signed 7/28/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

Bir. Pl. Int.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

06845

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 E. 1st St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Twin Smith

Baby Boy # 2 [redacted]

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1948

8. AGE:

Years	Months	Days	If less than one day
0	0	0	1 hrs. 50 min.

9. Birthplace Cumberland, Alleg. Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Raymond J. Smith
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden name Dorothy E. O'Neal
15. Birthplace Cumberland, Md.

16. Informant Raymond J. Smith

Address 109 E. 1st St. Cumberland, Md.

17. Burial Date thereof July 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory HillCrest Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. July 9 1948 Hunter R. Trautz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1948 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1948 to July 8 1948 and that I last saw h alive on July 8 1948

Immediate cause of death premature baby (6½ months)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Mings M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

Dr. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

CERTIFICATE OF DEATH

16846

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 E. 1st St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Boy Twin #1 Smith [redacted]

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 8, 1948

8. AGE:

Years	Months	Days	If less than one day
0	0	0	2 hrs. 30 min.

9. Birthplace: Cumberland, Md. Alleg. Co.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Raymond J. Smith

13. Birthplace: Cumberland, Md.

MOTHER

14. Maiden name: Dorothy E. O'Neal

15. Birthplace: Cumberland, Md.

16. Informant: Raymond J. Smith

Address: 109 E. 1st St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9, 1948 (month) (day) (year)

Cemetery or crematory: HillCrest Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. July 9 1948 Winter R. Gantz, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 1948 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1948 to July 8 1948 and that I last saw h alive on July 8 1948

Immediate cause of death: Premature baby (6½ months)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: G. Williams MD M. D. or other

Address: 58 Greene St. Date signed 7-8-48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within co... DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06847

13/a

Evidence for change of birth date shown on: FILM No. G 11 AUG 9 - 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 25 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: LONACONING
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
~~SMITH~~, ELIZABETH ~~[illegible]~~ Stafford Smith

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife: SMITH, WILLIAM
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): JAN. 29, ~~1870~~ 1872

8. AGE: Years	Months	Days	If less than one day
76	5	20	... hrs. ... min.

9. Birthplace: ~~KEN~~TUCKY (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business

FATHER
12. Name: STAFFORD, ~~JOHN~~ Thomas
13. Birthplace: ~~SCOTLAND~~ Lonaconing, Md

MOTHER
14. Maiden name: SNEDDON, JANET
15. Birthplace: SCOTLAND

16. Informant: Mr. Thos. Smith
Address: Lonaconing, Md.

17. Burial, cremation, or removal. Which?: Burial
Date thereof: July 22, 1948 (month) (day) (year)
Cemetery or crematory: Oak Hill
Location: Lonaconing, Md.

18. Funeral director: McEichhorn
Address: Lonaconing, Md.

19. July 20, 1948 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 19, 1948 at 5:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1948 to July 19 1948 and that I last saw h... alive on July 19 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	30 days
Due to: Hypertension Cardiac Vascular Renal disease	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: Same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel Jacobson M.D. M. D. or other
Address: 50 Pershing St. Date signed: 7/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

06848

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 211 N. Lee Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 2

3.(a) FULL NAME

Herbert O Springer

3.(b) Social Security Number

235-14-6662

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Daisy Landis

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): May 7, 1921

8. AGE: Years: 27 Months: 1 Days: 24 If less than one day: hrs. min.

9. Birthplace: Pickens, Randolph Co. W. Va.
(Town, county and state)

10. Usual occupation: Tire inspector

11. Industry or business: K-S Tire Co.

FATHER
12. Name: William Springer
13. Birthplace: Waverley, New York.

MOTHER
14. Maiden name: Ida Devenger
15. Birthplace: Webster Springs, W. Va.

16. Informant: Mrs. Daisy Springer

Address: 211 N. Lee St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 4, 1948 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. July 4 1948 (Date rec'd by registrar) W. L. Trauth, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1948 at 6.15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw him alive on July 1 1948

Immediate cause of death: Compound fracture of the skull, with extensive laceration of cerebrum & inter-

Due to: **cranial hemorrhage. Fracture comminuted femur bilateral, fractured

Due to: **ribs, puncture of right lung with subcutanous emphysema, due to injuries

Other conditions: received from plane crash.

(Include pregnancy within 3 months of death)

DURATION: 1 day

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 6-30-48

Where did injury occur? Wiley Ford (City or town) Mineral (County) W. Va. (State)

Injured at home, farm, industry, public place (where?): Municipal Airport

Means of injury: Tailspin Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. (M. D. or Coroner)

Address: Cumberland Md. Date signed: 7-1-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

06849

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:
327 Central Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 327 Central Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME

Albert Rufus Stephens

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 4 - 1934

8. AGE: Years	Months	Days	If less than one day
14	4	26	..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER
12. Name: John Lewis Stephens
13. Birthplace: Harrisonburg Va.

MOTHER
14. Maiden name: Hilda Marie Jones
15. Birthplace: Cumberland Md.

16. Informant: Mrs. John L. Stephens (mother)

Address: 327 Central Ave. Cumberland Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: July 4 '48
(month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Cumberland.

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. July 4 1948 (Date rec'd by registrar) W. R. Frank M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1948 at 4.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead July 1 1948

Immediate cause of death	DURATION
Pneumonic Meningitis	about 2 days
Due to: Lobar pneumonia, lower lobe bilateral	
Due to:	
Other conditions: tonsilitis	

(Include pregnancy within 3 months of death)

Major findings of operation: .....

Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or C. M.

Address: Cumberland Md. Date signed: 7-2-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

Dorrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06850

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 33 Henderson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Vina "Mort" Swede

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Alexander Swede

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): October 31, 1897

8. AGE:

Years	Months	Days	If less than one day
50	8	21	hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: Jacob Mort
13. Birthplace: ?

MOTHER
14. Maiden name: Price Price
15. Birthplace: Ohio

16. Informant: Alexander Swede

Address: 33 Henderson Ave., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26 1948 (month) (day) (year)

Cemetery or crematory: Camp Hill Cemetery

Location: Paw Paw, W. Va.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. July 23 1948 (Date rec'd by registrar) W. K. Crouch, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1948 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1934 to July 22 1948 and that I last saw her alive on July 15 1948

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Bronchial Asthma	15 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Clay F. Furrer M.D. or other

Address: Cumberland Date signed 7/28/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 06851

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
73 Hill St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 73 Hill St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Henry Snutzer
3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Mary Donegan
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): March 4 - 1864
8. AGE: Years 84 Months 4 Days 17 If less than one day hrs. min.
9. Birthplace: Hillman Alley, Md. (Town, county, and state)
10. Usual occupation: Retired Coal Miner
11. Industry or business
FATHER 12. Name: Henry Snutzer
13. Birthplace: Germany
MOTHER 14. Maiden name: Charlotte
15. Birthplace: Germany
16. Informant: Mrs. Lawrence Snutzer
210 Wylie Hill Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-24-1948 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: Jacob Hafer
Address: Frostburg, Md.
19. 7-24 1948 Mrs. Harvey H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21 1948 at 8 45 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-16 1948 to 7-21 1948 and that I last saw h. alive on 7-21 1948.

	DURATION
Immediate cause of death: Heart failure	1 month
Due to: arteriosclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Adolf Wolferman M.D.
M. D. or other
Address 134 E Main St. Date signed 7-22-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95C

06852

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Dead on arrival at Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 608 Ann Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edward Lee Tranum

3. (b) Social Security Number: None

4. Sex: male
5. Color or race: white
8.(a) Single, married, widowed, or divorced: widower

6.(b) Name of husband or wife: A. May Blizzard Tranum
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct. 12-1897

8. AGE: Years: 50 Months: 9 Days: 8 If less than one day ... hrs. ... min.

9. Birthplace: Brunswick Md.
(Town, county, and state)

10. Usual occupation: none (blind)

11. Industry or business

FATHER
12. Name: Patrick Tranum
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: H. V. Deming M.D.
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/24/48 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. July 23, 1948 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 19 48 at about 5.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw him alive Dead July 20 19 48

Immediate cause of death: Coronary occlusion — DURATION: about 1 hr.

Due to: coronary sclerosis

Due to:

Other conditions: Cardiac hypertrophy & pleural effusion
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. M. D. or other
Address: Cumberland Md. Date signed: 7-20-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits DR WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46d

06853

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 YEARS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 17 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 518 MARIETTA ST
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

MRS ORA ~~WEATHERWAX~~ Watherwax

3. (b) Social Security Number None

4. Sex: FEMALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: MARRIED

6.(b) Name of husband or wife: CHARLES ~~WEATHERWAX~~ Watherwax

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): APRIL 17 1890

8. AGE: Years 58 | Months 3 | Days 7 | If less than one day ... hrs. ... min.

9. Birthplace: W. VA
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business:

FATHER
12. Name: WILLIAM SCOTT
13. Birthplace: N.Y. CITY N.Y.

MOTHER
14. Maiden name: SARAH APPERSON
15. Birthplace: W. VA.

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVENUE

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 27 '48 (month) (day) (year)

Cemetery or crematory: Hillside Elm

Location: Cumberland

18. Funeral director: Louis Stein Inc
Address: Cumberland

19. July 27, 1948 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 24 1948 at 11:45 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to 24 July 1948 and that I last saw her alive on 24 July 1948

Immediate cause of death	DURATION
Carcinomatosis Generalized	
Due to: Carcinoma Rectum	
Due to:	
Other conditions: Jejuneal-Colon Fistula. Pt has voluntarily stayed in bed for past 14 yrs	

(Include pregnancy within 3 months of death)

Major findings of operation: Same above. Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fuller B. Mellwort M. D. or other

Address: 112 Beyond St. Date signed: 26 July 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

06854

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Frederick Wilson

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Fannie L. Wilson

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Jan. 31st, 1871

8. AGE: Years: 77 yrs Months: 5 mo Days: 7 da If less than one day: hrs. min.

9. Birthplace (town, county, and state): Cherrytrville Pa

10. Usual occupation: Groceryman

11. Industry or business

FATHER 12. Name: J. C. Wilson

13. Birthplace: Pa

MOTHER 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: George Bernard Wilson

Address: 2605 Irving St. N.E. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/11/48 (months (day) (year))

Cemetery or crematory: Hill Crest Burial Park

Location: Cumberland, Md.

18. Funeral director: Jacob Hafer

Address: 23 E. Main Street Frostburg Md

19. 7-10 1948 Mae Nancy N. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 July 1948 at 10 45 EST A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 May 1948 to 8 July 1948 and that I last saw him alive on 7 July 1948

Immediate cause of death: Coronary occlusion (Thrombosis)

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John B. Davis M.D. M. D. or other

Address: Frostburg, Md Date signed: 9 July 48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits DR. JACOBSON

06855

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Baltimore

City or town: TEXAS
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME
MR. HENRY WILSON

3. (b) Social Security Number
212-20-4391

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	SINGEL

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): MARCH 10, 1893

8. AGE: Years 55 | Months 4 | Days 12 | If less than one day ... hrs. ... min.

9. Birthplace: TEXAS, MARYLAND
(Town, county, and state)

10. Usual occupation: CARE OF RACE HORSES

11. Industry or business

FATHER
12. Name: MR. HENRY WILSON
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: NANCY DIVINE
15. Birthplace: MARYLAND

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVE.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/25/48 (month) (day) (year)

Cemetery or crematory: Foote Hill Cemetery

Location: Cockeysville, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. July 22 19 48 (Date rec'd by registrar) W. R. Trantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 22, 19 19 48 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 48 to July 22 19 48 and that I last saw him alive on July 21 19 48

Immediate cause of death: alcoholic cirrhosis of liver

DURATION: ??

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel Jacobson M.D. M. D. or other

Address: 50 Pershing St. Date signed 7/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

M

I

Outside of City Limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

0685B

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: R. D. #2 Cumberland,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
R. D. #2 Cumberland,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: R. D. #2
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Balti. Pike, Cumberland, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
PERRY CALVIN WILSON

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Connor

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): May 10, 1868

8. AGE:

Years	Months	Days	If less than one day
80	2	11	hrs. min.

9. Birthplace: Balto. Pike, near Cumb. Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER
12. Name: Moses R. Wilson
13. Birthplace: Maryland,

MOTHER
14. Maiden name: Christiana Mc Elfish
15. Birthplace: Maryland

16. Informant: Mrs. Margaret Wilson
Address: R. D. #2 Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: July 24, 1948
(month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland, Md.

18. Funeral director: H. Wayne George

Address: Cumberland, Md.

19. July 24, 1948 (Date rec'd by registrar) W. R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21, 1948 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1948 to July 21 1948 and that I last saw him alive on July 16 1948

Immediate cause of death: Chronic Myocarditis — DURATION: 2 years

Due to:

Due to:

Other conditions: Hemiplegia — 3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. W. Trevaskis, Dr. M.D.
M. D. or other

Address: Cumberland, Md. Date signed: 7/22/48